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ADMINISTRATIVE MANAGEMENT OF SMALL
GROUP PHYSICIAN PRACTICE

by

Richard A. Blanchette

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Administrative Management of Small Group Physician Practice

by

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ABSTRACT

This study reviews the administrative structure and management of physician office practices composed of two, three, or four physicians. It reflects the findings of a questionnaire survey about the operation of their private offices. Such areas as conflict resolution methodology and the structure of the decision making process among equals are included as well as an examination of the traditional workload factors that may be useful in comparing the efficiency of the organizations. An examination of five organizations within the sample space was conducted to obtain a qualitative perception of the administrative management of the organizations studied. Interviews and non-reactive observations were employed to obtain a more definitive view of the normal interactions between the members within each organization. The study identifies five characteristics that are symptomatic of inefficient organizations. Nine guidelines are prescribed for physicians who desire to improve the efficiency of their practices.

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I. INTRODUCTION

While discussing the decision making process in general purpose hospitals, Todd and Rice intimate that the professional literature is somewhat lacking in defining and describing organizational features within a profession. They suggest that "Perhaps control through a company of equals is more of an ideal state than an empirical phenomenon." They assert that "More research needs to be done in this area." [Ref. 1: p. 125] The management of professional organizations is of particular interest because the professionals that own the organization and, therefore, have an obligation to manage it are allegedly more interested in performing within their profession than they are in performing administrative tasks. There may be a tendency in such organizations to accentuate the professional duties at some detriment to the managerial duties and therefore at some loss of efficiency among the supporting structures.

What is the state of administrative management within professional organizations? How do such organizations make decisions? What happens when conflicting stances are taken by the equals? What is the present state of affairs in group practices of four or fewer physicians? Goss and others relate the paucity of information available about physician office practice. [Ref. 2: p. 5]

> What we know about the organization and performance of physicians in hospitals is considerable [when] compared with our knowledge about practitioners in their private offices. Here we are in the realm of outpatient or ambulatory care which, except in large group practices, occasional hospital clinics, and neighborhood health centers, has been given very little research attention with regard to either ogranization or performance of the physicians involved.

This study looks at the administrative structure and management of small group physician office practice. It reflects the findings of an empirical survey of 56 pre-selected physician group practices that were queried about the operation of their private offices. Such areas as conflict resolution methodology and the structure of the decision making process among equals are included as well as an examination of traditional workload factors that may be useful in comparing the administrative efficiency of the organizations studied.

After the surveys provided a general view of each practice in the sample space, a more detailed examination of five organizations within the sample space was conducted to evaluate, to the greatest extent possible, the validity of the initial survey and to obtain a qualitative perception of the administrative management of the organizations. Interviews and non-reactive observations were employed to obtain a more definitive view of the normal interactions between the members within each organization.

II. ORGANIZATIONAL CONSIDERATIONS

A. SMALL ORGANIZATIONS

"Management science as well as policy sciences so far have not investigated the problems of small- and medium-sized firms, but to a small extent. This is all the more surprising as, for example, some 95% of industrial firms are small- and medium-sized firms and empirical studies reveal that the main cause for failure of such firms is weakness of management." [Ref. 3: p. 30] Bamberger describes four properties that are typical of small organizations: [Ref. 3: p. 31]

1. Small- and medium-sized firms are usually family-owned firms. The principal owner is often identical with the top manager. His personality, values, convictions, education and experiences overwhelmingly influence policy decisions. Generally, he should be described as a man of action rather than a reflecting analyst as is typical for the strategic planner in a staff position.

2. The guidance system is strongly centralized. The owner-manager makes the most important policy decisions himself. His management style is very often paternalistic and tends to shy away from delegation and other forms of participation.

3. The guidance system is hardly differentiated and specialized. Because of the relatively small size of the firm the administrative area, too, is relatively small. The management is limited to the heads of functional areas which, as a rule, are not highly differentiated into clearly defined spheres of competence and authority. With a diminishing differentiation, the benefits of specialization and of the use of specialized knowledge diminish, too.

4. The information system is usually characterized by a low degree of formalization. Several empirical studies demonstrate that small- and medium-sized firms have often weaknesses in the production of internal and, especially, external information. External strategic information is typically produced by personal contacts of top management. The degree of synthesis of the information production and transformation which can be afforded by small- and medium-sized firms are rather limited.

Tibbets says that management of small organizations is an area that suffers simply because the organization does not have the specialized knowledge that is available to large firms. He contends that in a small firm, one person (the owner) is often saddled with solving all of the problems and with making all of the decisions. The hiring of consultants is often precluded when: [Ref. 4: p. 7]

1. The small business person views the use of consultants as an admission of failure,
2. The differences in education and background between the two parties preclude the development of a good working relationship,
3. The small business person does not know how to select an appropriate consultant, or
4. The potential benefits do not justify the cost.

Because one or more of the above factors is often present in a situation, the owner/manager has plenty of opportunity to do what Golde terms muddling through. Golde contends that muddling is the third stage of problem solving within the small organization. That is, if analysis and logic does not work, then intuition, instinct, or hunch will be tried. If they fail, then muddling through, a sort of conscious but non-logical thinking similar to lateral thinking and incrementalism will be applied to cope with the specific problem. Golde states that force fitting is a form of muddling and is best defined by this example: [Ref. 5: p. 152]

> We grab an existing handle and stuff the boggle into a suitcase already attached to the handle. We do not choose just any suitcase--we try to pick one that worked for seemingly similar kinds of problems in the past . . . Of course, the problem with force-fitting is that the boggle does not fit into the suitcase very well. We may have to push the problem all out of shape or else resort to major surgery by lopping off a few limbs of the situation. Force-fitting can be a very productive form of muddling if we sincerely try to mould both the suitcase and the problem over time so that the force fit gradually improves. We must realize that the initial fit is not a good one and represents merely a way to get moving.

Danco describes this type of coping as the blunder period and states that unfortunately the owner/manager ". . . does not generally look for the best talent to advise him--just the most available and the most pliable" [Ref. 6: p. 72]. Meanwhile, Bamberger relates that: [Ref. 3: p. 32]

> The decision processes are characterized more by a reactive, than by anticipative behavior. Management does not engage in contemplating long range problems but is busy with the resolution of urgent day-to-day problems. It does not try to achieve explicitly formulated objectives but is preoccupied with a continuous stream of problems requiring immediate attention. As a result, the information search behavior is limited by the status quo and the problems perceived. The components of business policy and the development of the firm are not planned, but are the result of a sequence of more or less disjointed, small steps.

Mintzberg, et al., report that a manager may not recognize a problem, and therefore the need for a decision, until a solution emerges. "A decision maker may be reluctant to act on a problem for which he sees no apparent solution; similarly he may hesitate to use a new idea that does not deal with a difficulty. But when an opportunity is matched with a problem, a manager is more likely to initiate decision making action." [Ref. 7: p. 253]

Decisions, therefore, tend to be made on an intuitive or subjective basis rather than the formal planning experienced in large organizations. Tibbits offers four suggestions relative to decision making in the small organization:

1. Small firms need to identify the determinants of their past successes to guide future decision making.

2. The manager must make time to keep in touch with the market and the environment.

3. The limited resources of the firm will mean that many complex problems face the manager. Recent analysis of muddling through provides practical guidelines for coming to grips with these complexities. Furthermore, these techniques are consistent with the incremental approaches to decision making in the firm and should, thus, be readily accepted by practical business people.

4. Decisions are often taken after less detailed analysis than would occur in large firms. The implication is that managers must be able to quickly identify which decisions are most pressing, and which involve substantial risks.

Suggestion number three implies that acceptance is an important issue in decision making. This social aspect is extremely important in the small organization. Pfeffer, Salancik and Leblebici posit that the nature of decision making will vary with the degree of uncertainty felt by the decision maker and the degree of social consensus expressed by the group being affected by the decision. [Ref. 8]

Louis provided some guidance in this area by suggesting that the decision maker is concerned with the level of social acceptance to the extent that social acceptance is required for effective implementation of the decision. If implementation will not be affected by social rejection of the decision, then the decision maker will not be as concerned by the rejection and will spend little time developing acceptance. If, on the other hand, it is impossible to implement the decision in the absence of social acceptance, the decision maker will spend a great deal of time developing acceptance. [Ref. 9]

The small firm is prone to be more susceptible to problems of this nature due to the dedication and loyalty invested in the organization by its early employees. Danco mentions that "This early participation in the business provides them with tenure in later years when key management positions are up for grabs." [Ref. 6: p. 68] Barry also recognizes this social obligation. He says that: [Ref. 10: p. 42]

> Any group of people in an unstructured or loosely structured situation will tend to develop relationships among themselves and thus their own pattern of informal group structure will emerge. Such informal relationships may be important not only in satisfying the socio-emotional needs of those concerned, but in a work organization may also be useful in

getting a task completed. Experience gained in building up a business may be expected to have led to a number of close friendships among those concerned and any attempt to introduce a more formal organization structure may be generally resisted.

Blau and Scott warn that the need to formally organize increases with size. "If a group is small enough for all members to be in direct social contact, and if it has no objectives that require coordination of activities, there is little need for explicit procedures or a formal division of labor. But the larger the group and the more complex the task it seeks to accomplish, the greater are the pressures to become explicitly organized." [Ref. 11: p. 215] The intracacies of small groups and business organizations are further complicated when force fitted to the whims of professionals.

B. PROFESSIONAL ORGANIZATIONS

Bucher and Stelling report that they have observed bothersome discrepancies between their empirical findings and the material found in the professional literature. They posit that "Weberian concepts of bureaucracy simply did not fit organizations dominated by professionals." [Ref. 12: p. 121] Etzioni relates that existing organizational theory contains three characteristic generalizations: [Ref. 13: p. 48]

1. Managers have the major (line) authority whereas experts deal with secondary activities, and therefore have only limited (staff) authority.

2. Institutional heads have to be manager-oriented because their role is a role of system integration. If an expert-oriented person were to hold this role, the system would be alienated from its goals and might even eventually disintegrate because some functions would be overemphasized while others would be neglected.

3. Organizational goals can be maintained more effectively in organizations with one center of authority.

The major goal of a professional organization is expertise. Managers, if there are any, administer the means to achieve the goal actually performed by the experts. In such organizations, managers are the staff and experts are the line. [Ref. 13]

The second generalization is a Catch-22 proposition for the professional organization. If an expert holds the position of institutional head, the orientation of the hierarchy will conform with the expert goals of the organization. However, the expert generally lacks the managerial sophistication required in order to obtain funds, recruit personnel, and allocate resources equitably. On the other hand, a nonexpert manager tends to emphasize productivity and return on investment at the detriment of the expert objectives. "Thus the role of head of professional organizations requires incompatible sets of orientations, personal characteristics, and aptitudes. If the role is performed by either a lay administrator or a typical expert, considerable organizational strain can be expected." [Ref. 13: p. 53-54]

The third generalization, that organizational goals can be maintained more effectively in organizations with one center of authority, runs into conflict with the dual lines of authority experienced in professional organizations, i.e., one line for administrative matters and a separate route for professional matters. Etzioni emphasizes that, ". . . in professional organizations there are indeed two types of authority but only the nonprofessional one is structured in a bureaucratic way with a clear line and center of authority." The nonprofessional segment is mainly responsible for supporting secondary activities and not for accomplishing the major goals of the professional organization. The expert professionals,

meanwhile, do not form a line of authority responsible for ensuring that the major goal activities are achieved. "In short, while there is an administrative line in professional organizations for secondary activities, there is no clear line in the major goal activities and to a large degree each professional is left to rely on his judgment, that is, he has final authority." [Ref. 13: p. 61]

Obtaining the authority to behave in such an autonomous fashion is a lengthy process that involves the following contingencies: [Ref. 12: p. 123]

1. The professional makes claims to competence in particular areas. He claims that he, uniquely, possesses the knowledge and skills to define problems, set the means for solving them, and judge the success of particular courses of action within his area of competence. To the extent that others accept these claims, the professional is accorded the license and mandate that is central to being professional.

2. Having his claims accepted in one area does not necessarily mean that the professional will have his claims accepted in other areas. By areas we mean both subject matter areas and different sectors of arenas of action within an organization. The competence or expertise claimed by the professional is specific; it is not necessarily generalized in other areas.

3. Having one's claims accepted is not a one-shot affair. The professional does not earn his status once and for all. Rather, it is a continuous process in which his claims to competence are being tested every day in interaction with others and he can lose the respect of others.

4. Even if one is accorded professional status, impinging on other people's areas of work can lead to challenges of claims.

When a professional enters an organization ". . . he builds his own place in the organization and creates the role he plays there." [Ref. 12: p. 124] This trait often leads to difficulty if the professional is to be part of a team. Bucher and Stelling say that a team ". . . is brought together to pursue a supposedly shared goal, to which each of the members is presumed to have a potential contribution." [Ref. 12: p. 127] An

individual joins a team and participates in an organization because he anticipates fulfilling his personal goals. Whenever progress toward achieving the personal goal is perceived to be thwarted, conflict will arise. [Ref. 14: p. 366-379]

Blankenship contends that in the collegial organization, conflict may promote withdrawal behavior. The behavior demonstrated may be a function of how the professional perceives his personal position and how he feels about obtaining his personal goals. [Ref. 15: p. 411]

> . . . when the importance of the personal career increases, unilateral decision making also increases, leading to more control crises. Crises reduce communication channels, forcing colleagues to create collective negotiations and leading to withdrawal or to submission, either of which reduces the importance of the personal career. When the importance of the personal career decreases, there is less unilateral decisin making and crises subside. Communication channels then expand and collective negotiation becomes unnecessary, requireing less withdrawal and submission, which restores viableness to personal careers.

This cycle allows integration through a more or less political process, "The political process in professional organizations involves a party phenomenon. Persons sound out colleagues in a search for allies." [Ref. 12: p. 133] Long term allies are often developed. So called deals are established for mutual support pacts. "In every troubled 'team' situation in our sample, cliques of team members have banded together to try to work out some position with respect to their dealings with others on the team." [Ref. 12: p. 133] Bucher and Stelling found this type of cooperation either very solid over a lengthy period of time or very fluid in the short term ". . . these alliances have a relatively fluid existence, ... Such factions represent groups of people who, perhaps only temporarily, share perspectives, who see common problems and common consequences of events." [Ref. 12: p. 133]

Blankenship relates that change is often the outcome of bargaining between professionals within an organization and that the small professional organization is generally less structured [Ref. 15: p. 142]. It is in such unstructured topsy-turvy organizations that most professionals function. The professional, therefore, has a greater opportunity for autonomy in the small organization.

C. PHYSICIAN ORGANIZATIONS

Systematic and reliable information about medical practice in the United States is incredibly scanty. The bulk of published material is composed almost entirely of special pleading or unsystematic individual impressions. [Ref. 16: p. 356] The typical mode of medical practice in the United States is solo practice. This involves a physician working by himself in an office which he secures and equips with his own capital and with patients who have freely chosen him as their personal physician and for whom he assumes responsibility. He does not have any formal connection with colleagues. Individual physicians are private enterpreneurs. They establish a private practice in any location in the community that they want, and they determine for themselves exactly what services they will provide in their own office. Their existence in their office practice is relatively uncomplicated and unregulated. [Ref. 17: p. 964] If no large capital is required for initiating a practice, and no consultation or institutions like hospitals are necessary for its pursuit, control by colleagues can be avoided and total autonomy approached. However, in order to take an evening or a weekend off, or a vacation, in order to be sick, a solo practice must be covered by colleagues who can be relied on to avoid stealing patients. A cooperative arrangement is

necessary. Other drawbacks of solo practice include: isolation from one's colleagues and thus from their information and support, the necessity to be preoccupied daily with the financial aspects of the practice, the financial leanness of the early and late stages of the career, and the difficulty of controlling and regularizing one's work hours. [Ref. 16: p. 355]

The physician, with his high social status, his strong subjective sense of importance, the privacy of his daily work and its fateful consequences, is better able to resist bureaucratic authority than any other professional field. [Ref. 16: p. 347] However, when the physician leaves his office for the hospital, he leaves a situation in which he is the master and enters an environment where he is one of many peers. The hospital situation is remarkably different from office practice. [Ref. 17: p. 964] Hospitals have evolved from domiciliary service to technical service. The hospital is perceived as a regimented organization that infringes upon the physician's freedom. The constraints of bureaucratic organization can engender skepticism and doubt in the physician's mind and hinder the development of a successful medical organization. Physicians sometimes find it difficult to understand why they must be organized. Why can't they simply walk into an institution, treat their patients, and be free from all committee responsibilities, reports, quality controls, bylaws, rules and regulations? All of these things seem far removed from the laying-on-of-hands and were seldom, if ever, discussed by professors in medical schools. [Ref. 18: p. 51]

There are four areas of physician conflict that seem to exist in hospital settings: first, resistance to rules; second, challenge of

standards; third, resistance to supervision; and fourth, only conditional organizational loyalty. [Ref. 19: p. 2] Resistance to rules stems from the physician's orientation as an independent problem solver. Physicians do not recognize any constraints to solution achievement, especially those established by a bureaucracy. [Ref. 19: p. 2] Hospitals, nonetheless, have had to move from simple organizational structures to much more bureaucratic and complicated structures in order to provide services that are increasingly more technical and complex. Physicians have shied away from the non-physician duties such as the organization and administration of hospitals. [Ref. 17: p. 969] They place greater value on membership in the profession of medicine than on loyalty to the hospital. [Ref. 19: p. 3]

In most hospitals, only one or two physicians participate actively at the governance level. ". . . many times phisicians are on governing boards primarily to protect their own interests rather than to participate actively in solving problems." [Ref. 20: p. 35] Physicians often feel that their ideas should exert influence within the hospital, on all matters and all subjects [Ref. 19: p. 3]. When their suggestions are not implemented, the physician does not understand why, and will become disappointed in the perceived inability of the organization to respond to his needs. The resultant confusion reinforces the physician's concept that bureaucratic organizations have too many rules and are too rigid.

Between the solo practice and the hospital is the group practice. Physicians form group practices to avoid the regimentation and lack of authority required by salaried employment in a medical institution, while also avoiding the lack of colleague support and erratic work hours of solo practice.

As health care delivery becomes more technical, a decline of solo practice, and an increase in group practice is a certainty. [Ref. 19: p. 5] Small group practices are more prevalent than large groups. A recent survey by the American Medical Association showed that 76 percent of the medical groups had three to five full-time physicians. [Ref. 16: p. 350] Group practices, however, are not ready-made and ready to serve. Beck and Kalogredis warn of some critical differences from solo practice: [Ref. 21: p. 28]

> Physicians practicing together, whether as partners or corporate shareholder-employees, find that group practice involves a number of considerations absolutely new to former solo physicians. The physicians involved may refer to their advisors for guidance regarding proper relationships, but they should recognize that no standard format will work for every group. Partnership details that are established for one satisfied group of doctors may be inappropriate for another group because of differences in medical specialties, styles of practice, professional philosophies, personal economic needs, ages, and personalities.
>
> The most important prerequisite for a successful group practice is for the doctors involved to have a solid understanding and appreciation of how they are going to work together. If they do not agree on their basic attitudes toward medical care, interchanging of patient responsibilities and the like, their relationship is unlikely to be a successful or lengthy one.

Cotton [Ref. 22], citing one group practice breakup, says the partners got sick of haggling over who was hired, who was fired, and who got a $5 raise. "We had a summit meeting about every little thing." Generally, each physician expects his view to count as much as the partner's. "I've found that a partnership is lucky if it has even one member who's willing and able to take on the full responsibility of decision-making." [Ref. 22: p. 66] Even this may cause problems; Cotton illustrates this point by the experiences of a group that had to make an unexpected policy decision. [Ref. 22: p. 120]

It was reached by majority vote. The decision was followed by an impromptu levelling session that cleared the air about a lot of pent up emotions. Included was a charge that ". . . I'd made too many decisions without consulting the group. When the others agreed, I got mad, too. I'd been making the business decisions only because nobody else would be bothered, I told them."

It gradually became evident that our setup had flaws. Every business procedure seemed to be multiplied by five. For instance, a separate set of books was kept for each doctor by his own nurse-secretary. Thus, the bookkeeper and her assistant, both of whom we shared, had to keep track of five sets of books, plus seven bank accounts--one account for each doctor, one for shared expenses and one for the lab. Further, there was really nobody in charge of our medical center. The girls directed their questions to whichever doctor was handy and so drew a mixture of conflicting answers. All of the problems were of an administrative management nature. The group finally went to a management consultant.

That resulted in assignment of authority for business matters to one person, subject to policy guidance by a board of owners. We now enjoy a new efficiency; one set of books, consistent fees, cheaper laboratory costs, and computerized billing.

Beck also provides some primary considerations that physicians forming a group practice should discuss and agree upon to reduce future problems: first, philosophy toward practicing medicine; second, method of dividing the income; third, deciding whether to form a partnership or a corporation; fourth, defining what is group income; and fifth, determining what expenses shall be borne by the group. He states that the cash required to begin the group practice should be kept to a minimum. Such a policy permits the physicians to practice medicine on out-of-pocket investments, which recognizes that their incomes should be due to their serivces and not to their capital investments. [Ref. 23: p. 112-113] Newhouse, however, posits that the main reason that physicians develop groups is to reduce the costs of obtaining capital equipment. Newhouse offers the example of the psychiatrist/radiologist to prove his capital motivation theory. Psychiatrists who have the least amount of capital outlay,

also have the lowest percentage of group practices. Meanwhile, radiologists that have the largest amount of capital outlay, also have the highest percentage of group practices. While the psychiatrist/radiologist capital motivation theory may be inviting, it ignores the depth of the patient/provider relationship. Any radiologist can read a radiograph and the impact on the patient is immaterial. Not just any psychiatrist can provide equal services to a patient. The patient is concerned about which specific provider the services are received from. There is a distinct difference between objective (radiology) and subjective (psychiatry) diagnosis and therapy. Newhouse says that, "Physicians do not fully maximize profits, but do charge higher prices when income raises demand. They are most likely satisficers rather than maximizers." [Ref. 24: p. 181] What he is saying is that regardless of capital equipment costs, or other costs of operations, physicians will charge whatever it takes to attain their desired annual income. Newhouse, therefore, contradicts himself by stating that capital equipment expense is a motivator for group practice while maintaining that physicians are not profit maximizers but price their services to obtain a certain income. If Newhouse is correct about physicians pricing their services to obtain a predetermined level of annual profit, the concept of just how easily one provider can be substituted for another with the least impact on the patient may be a larger consideration than capital costs in the development of small group practices. There would also be other considerations such as productivity and profitability.

Kimbell and Lorant report that the results of their studies indicate that there are increasing returns to scale for solo and small group

practice but decreasing returns to scale for very large groups. [Ref. 25: p. 367] They focused their studies on two questions: whether physicians are likely to be more productive in medical groups than in solo practices and whether large group practices are more productive than small ones. They report that physician productivity is higher in small group practices than it is in solo practice. [Ref. 25: p. 375] Nevertheless, solo firms remain the dominant form of medical practice; only about 20 percent of all physicians engaged in patient care in 1969 were in group practices. [Ref. 25: p. 367] This may be why the major thrust of health care legislation has been to encourage group practice. [Ref. 19]

Newhouse claims that group practice facilitates full utilization of physician resources immediately upon finishing training (rather than having a situation where the physician is underemployed while he is building up a practice) [Ref. 26: p. 52]. Kimbell and Lorant support him; they state that productivity is clearly higher in terms of gross revenue per physician in small group practices than in solo practices. Policies designed to encourage formation of small group practices promote higher physician productivity. But if there are indeed increasing returns to scale among small groups and decreasing returns to scale among large groups, why does this occur? "A major source of diseconomies of scale may be lack of disciplined control over costs." [Ref. 25: p. 378] Cotton cites an anonymous management consultant: [Ref. 25: p. 378]

> The other principal cause for the economic failure of groups is lack of sound fiscal control. Not a year goes by without my being asked to visit half a dozen groups with overhead trouble. I go and find they're netting less than half their gross. The gross itself is nearly always good. The trouble is they hire too much help, install fancy medical equipment they hardly ever use, put phones in every room, and go hog-wild on gadgets.

Dubois studied several group practices in depth and reported almost perpetual bickering among the physicians, with frequent changes in administrative arrangements, income sharing schemes, and the like [Ref. 25: p. 378]. "Authors of studies of unsuccessful medical group practices have concluded that failure to observe basic principles of organization and management was the cause . . ." [Ref. 27: p. 7] Strumpf notes that his studies show that lack of management capability to be a major cause of Health Maintenance Organizations having their federal funds terminated. Beck testifies to the consistency of physician managerial inattention: [Ref. 23: p. 114]

> I am consistantly amazed at the number of group practices having no idea of their collection ratios, their accounts receivable outstanding, and other basic management information. Common sense seems to require regular bookkeeping and reporting so that such items remain within the partners' knowledge.

In general, increasing returns to scale appear to operate powerfully at the low end of the practice size, whereas managerial difficulties increase with the size of the practice. When both the physicians' and the patients' perspectives are considered, Newman has found that three is the magic number. He encourages the idea of the personal doctor while avoiding the image of three doctors running three separate solo practices under one roof. Unless new patients make specific requests, they are allocated to one of the partners on a numerical basis to keep the workload even. Most patients see all of the physicians eventually, although many have their preferences. [Ref. 28: p. 23]

Newman feels that open access is essential. He cites an example: [Ref. 28; p. 24]

> Although we are located 100 yards from a new purpose-built health centre that runs a system of appointments only, we are embarrassingly

deluged by a constant flow of patients wishing to change--not to us, we believe, but to our system, where the doctor can be seen if necessary on impulse, on the same day.

If we had a large number of patients necessitating an increase in the number of partners beyond three, I do not think that we could maintain the old tradition of personalised family medicine and fulfill the concept of the personal doctor. I have been fortunate for a quarter of a century in living and working in a happy practice, and I cannot see any way in which enlarging it beyond the number of three would enable me to continue this happy professional life.

If you can get it right, three is the magic number.

Newman's attitude is supported by Freidson who says, "Physician's satisfaction may be more influenced by the arrangement of his work than by the arrangement of his payment." [Ref. 16: p. 354] Cotton agrees that small groups are popular with patients. He says that patients like partnerships. They feel secure because they know that if you are not available they will be taken care of by someone that they are already acquainted with and that you trust. The substitute physician is not a stranger, and the receptionist, nurse and other office staff are all acquainted with the patient. The avoidance of strange surroundings helps to keep the anxiety level of the patient as low as possible and therefore increases the effectiveness of the diagnosis and treatment.

Group practices are steadily replacing solo practice as the dominant mode of delivering health care. The literature did not report any studies that concentrated on the administrative management or group decision making processes of small group physician practice. The literature indicated that small groups of two, three, or four physicians are the most popular as well as the most productive and profitable arrangement, but it related the reasons to vague concepts such as professional philosophy, age differences, and personalities. Managerial

philosophy and decision making processes are unknown factors in such organizations. This study enters into the offices of private small group physician practices and reports on the administrative management and decision making processes discovered therein.

III. PROCEDURAL CONSIDERATIONS

A. BACKGROUND

The impetus for this study was conceived during a review of previous theses completed by health care administrators. Todd and Rice [Ref. 1] introduced the notion that decision making among equals was an area that contained very little empirical data. Stimulated by their observations, a pilot study was conducted that involved general interviews of 32 professional organizations of varying specialties such as dentists, doctors, lawyers, and accountants. The pilot study showed a great diversity in management styles. Persistent review of the literature narrowed the scope of the study to physician organizations, then to office practices, and finally to small groups of four, three, or two physicians.

B. DEVELOPMENT OF THE QUESTIONNAIRE

The focus of the study was to document how administrative management and decision making within small group medical practices are conducted. The organizations were not sole proprietorships, therefore, complete autocratic control by one person seemed unlikely. Just how, then, were these organizations managed? Who made the daily administrative decisions? How are hirings, firing, and pay raises decided? A survey questionnaire was developed to obtain some answers to these questions (Appendix A). The pilot study questionnaire format was developed from Beach [Ref. 29]. The five management functions of planning, organizing, staffing, directing, and controlling, along with the five personnel functions of policy initiating and formulating, recruiting, interviewing and hiring, wage and salary

administrating, and discipline and discharge, were selected as being indicative of the management philosophy of the organization. It soon became apparent that the format was too rigid. People seemed to have difficulty relating the management terminology to the actions they experienced in their daily operations. Development of the survey questionnaire required transferring management principles into daily terminology. The pilot study had shown that terms such as the functions of management and personnel functions were abstract concepts in physician offices. For instance, when asked who did the salary administration or who did the directing and controlling, the respondents provided a large proportion of either blank stares or mechanical responses. The wording of the question list for the pilot study was updated several times until the respondents were able to understand what was being asked and were able to respond by providing the data sought.

Each of the 15 items in the final questionnaire for this study were evaluated for clarity and understanding. For instance, "Who makes the routine daily administrative decisions?" is a simply stated concept that relates to: Who does the directing and controlling? Each item in the questionnaire follows that basic structure, although it may not be as obvious. Another example might be useful. The question, "Is there any one person that tends to initiate discussion on changing things?" relates to the personnel function of policy initiation and formulation.

To obtain a variety of perspectives on the questionnaire, it was independently reviewed by five health care administrators during the development stage. Their comments and suggestions were helpful in removing confusing terminology from the questionnaire. A prototype

questionnaire was then produced and sent to a physician group with the request that it be analyzed for clarity. The suggestions that the physician group provided added still another perspective to the questionnaire design and were immediately adopted. The final questionnaire format was then distributed to the entire sample along with the cover letter explaining the purpose of the study (Appendix A).

C. THE SAMPLE SPACE

The selection of 56 physicians in the sample was dictated by the interest and the available information about physician groups in the local area. All organizations that were identified as physician office group practices of two to four physicians within the local area were included in the sample. The county medical society and the yellow pages of the telephone directory were the principal sources. One physician from each group practice was randomly selected to receivce the questionnaire. The questionnaire was mailed, along with a postage paid reply envelope and an individually addressed cover letter, to each physician.

D. STIMULATING A RESPONSE

Telephone follow-up on non-responses was attempted one week after the initial questionnaire was mailed. The telephone follow-up was not effective because the individual physicians could not be reached. Receptionists or nurses consistently protected physicians with responses such as:

1. He's with a patient, can I have him call you back?
2. He has not come in yet.
3. He has left for the day.

4. I have not had the chance to ask him about that. I'll check tomorrow.

5. He says he doesn't remember seeing it.

6. He's at the hospital all day today. I'll ask him about it tomorrow.

One month after the initial questionnaire was mailed, a follow-up copy was mailed to non-respondents. It was identical to the first mailing except for a self adhesive label placed on the cover letter (Appendix A).

E. OBTAINING INTERVIEW APPOINTMENTS

After receiving the physicians' responses, follow-up interviews and observations were conducted with a sampling of the organizations to obtain more data on the managerial philosophies of physicians and to discover if any areas of importance to the physician were not addressed by the questionnaire. As alluded to earlier, all attempts to talk with a physician were effectively blocked by the office staff. All communications were filtered through the staff to the physician and back again. In order to arrange a personal interview with the physician, it was essential to convince the staff person that the physician was really interested in the study and that the physician, and possibly the entire staff, would benefit from the encounter. In the absence of a positive endorsement from the staff person, the probability of obtaining an interview with the physician was slim. There was, in fact, no way of ascertaining whether or not the request for an interview was ever presented to the physician. The physician's staff is, after all, paid to screen telephone calls and to truncate those of little significance. Using the telephone method to obtain personal interviews with the physician was complex, cumbersome,

and time consuming. Those interview appointments that eventually were granted were for 15 to 20 minute periods during lunch time, or at the end of office hours at 5:00 p.m., or later. The high value placed on the physician's time was consistently transmitted by each staff person who assisted in arranging an appointment.

IV. FINDINGS

A. BACKGROUND

This section reports the results of the survey questionnaire (Appendix A) which was mailed to 56 physicians in the local area. After one month, 16 of the 56 questionnaires were returned; 13 were usable. A second mailing to the 40 non-respondents produced an additional 13 responses of which six were usable. In all, 19 usable responses were received for an overall effective response rate of 34%. Justification for the rejection of the ten non-usable responses was provided in the previous section. The remainder of this section refers only to the 19 survey questionnaire responses that were accepted.

B. DATA PRESENTATION

This subsection reports the data obtained for each variable in the questionnaire by tables of frequencies. Statistical data is omitted for nominal or ordinal variables. The category names are directly related to the alternatives listed in the questionnaire (Appendix A). Owners A, B, and C are anonymous labels given to the partners within the practice by the respondent. The labels were used consistently by the respondent while answering each item in the questionnaire.

Table 1 reports that the office manager is the person sought after to make the daily decisions for a practice. The decision making line of authority is diffused by the second most popular method of daily decision making which is the category of "All Owners by Agreement." This category insinuates that mini-meetings are held throughout the day for the

TABLE 1

ROUTINE DAILY DECISION MAKER

Who makes the routine daily administrative decisions?

Category	Absolute Frequency	Relative Frequency (Percent)
Owner A	3	16
Owner B	1	5
Office Manager	9	47
Majority	1	5
Whoever's Around	1	5
All Owners by Agreement	4	21
Total	19	100

purpose of making routine administrative decisions. Unfortunately, that is exactly what happens in many cases. One office manager related that the physicians griped when she insisted on weekly business meetings. They later commented on how much time the meetings saved by not disturbing patient care to make business decisions.

TABLE 2

PERSON(S) THAT SIGN CHECKS

Who signs the checks for the group practice?

Category	Absolute Frequency	Relative Frequency (Percent)
Owner A	3	16
Owner B	1	5
Owner C	1	5
Office Manager	4	21
Whoever's Around	5	26
Any Owner	5	26
Total	19	100

Table 2 indicates that in very few cases is signing checks restricted to one person. The category of "Whoever's Around" includes the office manager while "Any Owner" does not. Combining the "Office Manager" and "Whoever's Around" categories shows that this duty is almost evenly shared by the owners and office manager. Because there is only one office manager and at least two owners, the office manager is likely to be the check signer at least twice as often as any one of the owners.

TABLE 3

PERSON(S) THAT DECIDE HIRING, DISMISS, ETC.

Who makes decisions on personnel matters such as hiring, discipline, dismissal, and pay raises?

Category	Absolute Frequency	Relative Frequency (Percent)
Owner A	3	16
Office Manager	1	5
All Owners by Agreement	15	79
Total	19	100

Table 3 shows that all owners are likely to be involved in decisions that concern employee personnel practices. Relatively few organizations delegated personnel policy decisions to another owner, and only one organization gave the office manager that much responsibility and authority.

The majority of organizations in Table 4 do not have a particular individual that suggest changing things. The perception is that ideas for change are obtained from a variety of individuals within the practice. A surprising finding was that there were no cases where a respondent felt that an employee other than the office manager was an initiator of change.

TABLE 4

PERSON THAT INITIATES CHANGE

Is there any one person that tends to initiate discussion on changing things?

Category	Absolute Frequency	Relative Frequency (Percent)
Owner A	5	26
Owner B	1	5
Owner C	1	5
Office Manager	1	5
No One Person	11	58
Total	19	100

Not one receptionist, billing clerk, or nurse was cited as playing a dominant role in this very important function.

TABLE 5

HOW GENERAL MANAGEMENT DECISIONS ARE REACHED

How are management decisions reached within your organization?

Category	Absolute Frequency	Relative Frequency (Percent)
Consensus	15	79
Bargaining	1	5
Procrastinate	1	5
Dominant Prevails	2	11
Total	19	100

Table 5 documents the perceived participative management style of the physician office practices. The majority of organizations reach management decisions by cooperation and involvement. Decision making by both consensus and bargaining requires considerable interaction and a concern for the perspectives of others. These findings are consistent with those of Table 4; both indicate a minimal presence of an autocratic management style.

TABLE 6

HOW STRONG DISAGREEMENT IS RESOLVED

How would a situation of strong disagreement between the partners be resolved?

Category	Absolute Frequency	Relative Frequency (Percent)
Unknown	2	11
Consensus	9	47
Bargaining	4	21
Procrastinate	2	11
Continual Conflict	1	5
Dominant Prevails	1	5
Total	19	100

Table 6 shows that consensus and bargaining are the most widely used ways of resolving conflict among equals. Of considerable interest are the responses of unknown. Do they indicate that strong disagreement has never occurred among the partners, or do they indicate that the strong disagreements that have occurred just magically disappear?

TABLE 7

NUMBER OF MINUTES AVERAGE PATIENT WAITS

What is the average length of time a patient spends in the waiting room?

Minutes	Absolute Frequency	Relative Frequency (Percent)
10	5	26
15	6	32
20	4	21
25	1	5
30	2	11
60	1	5
Total	19	100

Mean 19; Standard Deviation 12; Median 16.

Table 7 shown that only a small minority of physician offices allow their patients to sit in the waiting room longer than 20 minutes. Most people wait less than 15 minutes. These data represent the physician's perspective of the waiting times of his patients. What actually happens may be different. The physician may be quite unaware of actual waiting times.

TABLE 8

NON-CONSULTING SPENDING LIMIT OF PARTNERS

What dollar value would one owner feel comfortable spending on a one-time basis without consulting other owners?

Dollars	Absolute Frequency	Relative Frequency (Percent)
0	2	10
25	2	10
50	2	10
100	7	37
200	1	6
300	2	10
500	3	16
Total	19	100

Mean 166; Standard Deviation 171; Median 100; Mode 100.

Table 8 discloses the amount of money a partner could comfortably spend on a non-recurring item without consulting the other partners. Most of the respondents cited the ceiling at as little as $100; another large segment was even lower at $50, $25, and nothing. The dollar values cited were a surprise; especially when compared to the high cost of medical care.

Table 9 shows that the quotient of the total outstanding accounts receivable (divided by the average gross monthly earnings) was not a popular measure of the efficiency of an office staff. Over half responded that it was not. Nonetheless, a large portion responded that it was.

TABLE 9

ACCOUNTS RECEIVABLE AS A MEASURE OF EFFICIENCY

Do you believe that the ratio of accounts receivable over gross monthly earnings is the best way to measure administrative efficiency in your office? __ Yes __ No

Category	Absolute Frequency	Relative Frequency (Percent)
Not Effective	11	58
Effective	7	37
No Response	1	5
Total	19	100

TABLE 10

NUMBER OF OFFICE VISITS

Total number of office visits per month (average).

Visits	Absolute Frequency	Relative Frequency (Percent)
100	1	5.6
200	1	5.6
240	1	5.6
250	1	5.6
300	1	5.6
360	1	5.6
600	1	5.6
623	1	5.6
800	1	5.6
850	1	5.6
1,000	3	16.7
1,300	1	5.6
1,560	1	5.6
2,000	3	16.7
Missing	1	
Total	19	100.0

Mean 899; Standard Deviation 645; Median 805.
Bi-Modal at 1,000 and 2,000 office visits.

Table 10 shows the range of 1,900 in the average number of patients seen each month. The range seems too large to be justified by variances in specialties alone. The number of visits are for all physicians at the addresses the survey was mailed to. Some physicians have two or more group practices with different partners at different addresses and may only practice at a particular address one day per week.

TABLE 11

NUMBER OF FULL TIME STAFF

Total number of administrative and professional staff (include physicians) full time ____.

Number of Staff	Absolute Frequency	Relative Frequency (Percent)
4	1	5
5	4	21
6	2	10
7	3	16
8	3	16
9	1	5
10	1	5
11	2	10
13	1	5
15	1	5
Total	19	100

Mean 8; Standard Deviation 3; Median 7; Mode 5.

Table 11 exhibits the staffing levels of the physician offices. Most of the small group practices have staffs of eight or fewer. Those offices with two physicians generally have staffs of four to eight people. Three-physician groups tend to have six to thirteen people, while four-physician groups have seven to fifteen full time people.

Table 12 shows the part time staffing levels. The levels are very evenly distributed except for the one organization that has an extreme of seven part

TABLE 12

NUMBER OF PART TIME STAFF

Total number of administrative and professional staff (include physicians) full time ____.

Number of Staff	Absolute Frequency	Relative Frequency (Percent)
0	5	26
1	4	21
2	5	26
3	4	21
7	1	5
Total	19	100

Mean 1.7; Standard Deviation 1.7; Median 1.6.

time employees. There was no discernable trend between the number of part time employees and the number of physicians in the group. Nor was there any relation to the number of office visits per month. The organization with seven part timers is a four-physician group that has only 850 office visits per month.

Table 13 displays the ratio the accounts receivable are of the average gross monthly earnings. The majority of the practices have a ratio of three or less. This means that their outstanding accounts receivable are less than three times their gross monthly earnings. The physicians, on the average, get their money three months after they earn it. Almost a quarter of the practices wait four months and one organization waits an astonishing eight months. The eight month figure was verified with the physicians's bookkeeper. At the other extreme, one organization manages to get paid in only 1.8 months. This measurement was cited most often in the pilot study as the baseline measure of office efficiency.

TABLE 13

RATIO OF ACCOUNTS RECEIVABLE

Ratio of accounts receivable divided by gross monthly earnings.

Ratios	Absolute Frequency	Relative Frequency (Percent)
1.80	1	7
2.00	1	7
2.17	1	7
2.48	1	7
2.50	1	7
2.75	1	7
3.00	2	14
3.10	1	7
3.70	1	7
4.00	3	21
8.00	1	7
Missing	5	
Total	19	100

Mean 3.32; Standard Deviation 1.54; Median 3.00; Mode 4.00

TABLE 14

RATIO OF EMPLOYEE LABOR COST

Monthly employee labor cost (excluding owners) divided by gross monthly earnings

Ratio	Absolute Frequency	Relative Frequency (Percent)
0.086	1	7.7
0.100	1	7.7
0.112	1	7.7
0.116	1	7.7
0.143	1	7.7
0.146	1	7.7
0.150	1	7.7
0.166	1	7.7
0.170	1	7.7
0.240	1	7.7
0.250	1	7.7
0.333	2	15.4
Missing	6	
Total	19	100

Mean 0.180; Standard Deviation 0.083; Median 0.150; Mode 0.333.

Table 14 tells what percentage of the gross monthly earnings are spent on employee labor. The majority of the practices spend 15 percent or less. Extremely surprising were the organizations that reported a full one third of their gross earnings are absorbed by employee labor. That percentage is almost four times the smallest ratio and more than 30 percent higher than the next highest organization.

TABLE 15

RATIO OF OPERATING COST TO EARNINGS

Total monthly operating costs (including employee labor) divided by gross monthly earnings.

Ratios	Absolute Frequency	Relative Frequency (Percent)
0.28	1	7
0.32	1	7
0.34	1	7
0.35	1	7
0.38	1	7
0.40	1	7
0.45	1	7
0.50	1	7
0.54	1	7
0.63	1	7
0.65	1	7
0.67	2	14
0.73	1	7
Missing	5	
Total	19	100

Mean 0.49; Standard Deviation 0.15; Median 0.46; Mode 0.67

Table 15 reflects the percentage of the gross monthly earnings that is absorbed by the operating costs of the organization. The percentage that is left over pays the owners' salaries, taxes, reduces principal on debt, and perhaps allows some capital improvements to be accomplished.

Exactly half of the practices reported operating cost ratios of 45 percent or less. Comparison of this variable with each of the other variables produces a strong association with the routine decision maker for the higher cost percentages. In three of the four cases where the routine decisions involve "All Owners," the operating costs are 63 percent or higher. At the same time, in three of the four cases where the routine decision maker is the office manager, the operating costs are 38 percent or less.

TABLE 16

OPERATING COST PER OFFICE VISIT

Total monthly operating cost (including employee labor) divided by number of office visits per month.

Ratio	Absolute Frequency	Relative Frequency (Percent)
10.00	1	7.7
21.00	1	7.7
22.00	1	7.7
22.23	1	7.7
23.72	1	7.7
25.00	2	15.4
25.86	1	7.7
35.00	1	7.7
40.00	1	7.7
42.00	2	15.4
52.24	1	7.7
Missing	6	---
Total	19	100

Mean 29.70; Standard Deviation 11.61; Median 26.06.
Bi-Modal at $25.00 and $42.00.

Table 16 reveals how much it costs the organization to see the average patient. The table shows that for the majority of the practices, the cost is $25.00 or less. Most organizations fell within the $15.00

spread of $10.00 to $25.00. The next $15.00 segment absorbed half of the remaining organizations while it took almost another full $15.00 segment to contian the highest cost organizations.

C. GENERAL TRENDS

The data presented in this subsection were cross-tabulated and analyzed for trends and connections. The analysis disclosed some connections that were expected and some that were unforeseen. One of the expected findings was attained by comparing the method used to reach management decisions with the method used to resolve strong disagreement.

TABLE 17

MANAGEMENT DECISIONS/STRONG DISAGREEMENT

When Management Decisions Are Reached by:	Strong Disagreement is Resolved by:	In Number of Group Practices:
Consensus	Consensus	8
	Bargaining	2
	Procrastinating	1
	Continual Conflict	1
	Dominant Prevails	1
	Unknown	2
Bargaining	Bargaining	1
Procrastinating	Procrastinating	1
Dominant Prevails	Consensus	1
	Bargaining	1
Total		19

As expected, when consensus is the method used for resolving strong disagreement, it is also the method used for reaching management decisions in most cases. A difficult to understand relationship is the case where management decisions are reached by consensus and strong disagreememt is resolved by the dominant partner prevailing. Another organization

reported that management decisions are reached by the dominant partner prevailing but strong disagreement is resolved by consensus. The case whereby both management decisions and strong disagreement are handled by bargaining, or the case whereby both management decisions and strong disagreement are handled by procrastinating are easier to comprehend.

TABLE 18

MANAGEMENT DECISIONS/ROUTINE DAILY DECISION MAKER

When Management Decisions Are Reached by:	Routine Daily Decisions Are Made by:	In Number of Group Practices:
Consensus	Office Manager	8
	Owner A	2
	Owner B	1
	Majority	1
	Whoever's Around	1
	All Owners	2
Bargaining	All Owners	1
Procrastinating	All Owners	1
Dominant Prevails	Owner A	1
	Office Manager	1
Total		19

Continuing with the management decision variable and comparing it with the routine daily decision maker variable reveals that an organization that makes management decisions by consensus is likely to have an office manager that makes the routine daily decisions. Table 18 shows that when consensus is the management style, the office manager performs the daily decision making tasks four times more often than "Owner A" or "All Owners".

Table 19 indicates who the routine daily decision maker is in relation to the number of physicians in the group. It was no surprise

TABLE 19

NUMBER OF PHYSICIANS/ROUTINE DAILY DECISION MAKER

When the Number of Physicians is:	Routine Daily Decisions Are Made by:	In Number of Group Practices:
2	Owner A	2
	Office Manager	3
	All Owners	3
3	Owner B	1
	Office Manager	3
	Majority	1
	All Owners	1
4	Owner A	1
	Office Manager	3
	Whoever's Around	1
Total		19

to notice that "All Owners" are the routine daily decision makers in the smaller two-physician practices much more often than in the three-physician practices. The concept of "All Owners" making the daily decisions implies mini-meetings throughout the day. Two people can get together spontaneously; with three, it is more difficult and with four, it is virtually impossible. Table 19 supports this position. It shows that in the four-physician groups the routine daily decision maker is "Whoever's Around" instead of the smaller group category of "All Owners". Notice also that the routine decision maker of "Majority" was only cited for three-physician groups. Majority is non-sensical for two-physician groups, and it is extremely cumbersome to obtain a series of three-out-of-four alliances on routine decisions throughout the normal work day. In the four-physician groups, the decision making task is assigned to one person with the one exception of the default category "Whoever's Around". In two and three-physician groups, the routine decision making task is much

more frequently performed by a group of two or more of the owners when the task is not performed by the office manager. Note also that the office manager is the most likely rotine daily decision maker in three- and four-physician groups, but is just about even with the other categories for the two-physician practices.

TABLE 20

NUMBER OF PHYSICIANS/PERSONNEL DECISIONS

Number of Physicians	Person(s) That Decide Hiring, Dismissal, etc.			
	Owner A	Office Manager	All Owners	Total
2	1	1	6	8
3	2	0	4	6
4	0	0	5	5
Total	3	1	15	19

Exchanging the routine decision maker variable for the non-routine decision making methods concerning personnel practices such as hiring, discipline, pay raises, and so forth, reveals that physicians share these decisions to a much greater extent than the routine ones. Every one of the four-physician groups reached the personnel decisions by involving "All Owners." The "Majority" and "Whoever's Around" categories were completely eliminated from the cross-tabulation. The physicians either wanted to firmly set responsibility for the personnel decisions on one person, or they wanted all of them to share the responsibility equally. As Table 20 shows, one person decision making was allowed in a few of the two- and three-physician groups, but sharing the decision on personnel issues was the most predominate method.

D. NUMERICAL TRENDS

The previous subsections analyzed nominal data that does not differentiate between higher and lower or better and worse. It simply documented whether Owner A or Owner B performed such and such a function. The discussion now moves to interval data and ratios of costs where there is a measurable difference between 10 percent and 30 percent.

TABLE 21

EMPLOYEE LABOR COST/NUMBER OF FULL TIME STAFF

Ratio of Employee Labor Cost	Number of Full Time Staff
0.086	7
0.100	8
0.112	8
0.116	9
0.143	4
0.146	11
0.150	6
0.166	7
0.170	11
0.240	5
0.240	6
0.250	5
0.333	10
0.333	13

Table 21 compares the ratio of the average gross monthly earnings that is spent on employee labor with the number of full time staff. Although the relationship is disturbed by the two organizations that have a staff of 11, the table indicates that, in general, those organizations that have a staff of seven, eight, or nine people spend less that 12 percent of their gross earnings on salaries, while those organizations with staffs of four, five, or six spend 14 to 25 percent on salaries. Finally, those organizations with staffs of 10 or 13 spend an enormous 33 percent of

their gross monthly earnings on employee salaries. As stated above, the two outlier organizations with a staff of 11 disturb the trend. Further analysis did not explain the exception to the general trend.

TABLE 22

NUMBER OF OFFICE VISITS/NUMBER OF FULL TIME STAFF

Number of Office Visits	Number of Full Time Staff
100	4
200	5
240	5
250	5
300	9
360	7
600	6
623	11
800	6
850	7
1,000	7
1,000	8
1,000	11
1,300	8
1,560	15
2,000	8
2,000	10
2,000	13

There was no clear association between the number of full time staff and the number of office visits. A minimal staff of four or five is probably required up to approximately 250 visits per month. Thereafter, the volume of patients seen is not an indicator of the number of staff personnel.

Table 23 compares the percentage of income that is spent on employee labor with the non-consultant spending limit of partners. The table shows that the three highest dollar value entries ($300 and $500) match the three lowest employee cost ratios. The next three lowest employee

TABLE 23

EMPLOYEE LABOR COST/NON-CONSULTING SPENDING LIMIT

Ratio of Employee Labor Cost	Non-Consulting Spending Limit
0.086	$300
0.100	$500
0.112	$500
0.116	$ 25
0.143	$ 00
0.146	$ 50
0.150	$100
0.166	$100
0.170	$ 50
0.240	$200
0.250	$100
0.333	$100
0.333	$ 25

cost ratios match the lowest dollar value entries ($50, $25, and $0). Except for the one $25 entry at the 33 percent ratio, all other data is in the middle of the dollar value range and in the highest employee ratio categories. The significance of this finding is that it tends to indicate that trust values (as measured by the non-consulting spending limit) at the extremes, either high trust or low trust, are both associated with lower percentages of costs for employee labor. At the same time, trust values in the middle, sometimes termed wishy-washy, are associated with the higher employee labor costs.

The trust value measurement did not develop a pattern when compared with the ratio of total operating costs. This indicates that employee labor costs are much more sensitive to trust value than the total operating costs. The indication is reasonable because total operating costs contain large portions of long-term fixed costs that are not susceptible to daily management style or people productivity. The decisions concerning

long-term fixed costs are more analytical and less emotional-based than are the personnel hiring and pay raise decisions that influence the employee labor costs.

TABLE 24

RATIO OF OPERATING COST/PERSON THAT INITIATES CHANGE

Ratio	Change Initiator
0.28	Owner C
0.32	Owner A
0.34	Office Manager
0.35	No One Person
0.38	Owner A
0.40	Owner B
0.45	No One Person
0.50	Owner A
0.54	No One Person
0.63	No One Person
0.65	No One Person
0.67	Owner A
0.67	No One Person
0.73	No One Person

Comparing the ratio of the operating cost with person that initiates change shows that operating costs are lower when there is a single person that initiates discussion on changing things. Six practices reported operating costs above 50 percent; of those six, five did not have a one-person initiator of change. It is unclear whether more than one person initiates change in these organizations or whether no one initiates change. Whichever the case may be, it is clear that there is a strong association between having a one-person initiator of change and reduced operating costs.

Comparing the ratio of the operating cost with the routine daily decision maker revealed that in four of the five lowest operating cost

TABLE 25

RATIO OF OPERATING COST/ROUTINE DAILY DECISION MAKER

Ratio	Decision Maker
0.28	Office Manager
0.32	Office Manager
0.34	Office Manager
0.35	Whoever's Around
0.38	Office Manager
0.40	Owner A
0.45	All Owners
0.50	Owner A
0.54	Office Manager
0.63	All Owners
0.65	Owner B
0.67	All Owners
0.67	Majority
0.73	All Owners

ratio organizations, the routine decision maker was the "Office Manager." At the same time, in four out of five of the highest operating cost ratio organizations, the routine decision maker was either "All Owners" or "Majority." There is an indication that for routine decision making, group effort is not cost effective. The office manager produced the lowest ratios, followed by various individual decision makers, with the group decision makers at the highest ratios of operating costs.

Comparison of the ratio of the operating costs with the ratio of accounts receivable produced surprising results. During the study, a majority of organizations had reported that the most important measurement of efficiency was the ratio of the accounts receivable. However, Table 26 shows that the five lowest ratios of accounts receivable are all associated with the higher operating costs of 54 to 67 percent. This suggests rather strongly that the cost of keeping the accounts receivable

TABLE 26

RATIO OF OPERATING COST/RATIO OF ACCOUNTS RECEIVABLE

Operating Costs	Accounts Receivable
0.28	4.00
0.32	3.00
0.34	3.70
0.35	3.10
0.38	2.75
0.40	8.00
0.45	4.00
0.50	3.00
0.54	2.17
0.63	2.00
0.65	2.48
0.67	1.80
0.67	2.50
0.73	4.00

ratio low is expensive in the long run. The table does not indicate that the opposite is true, however. The highest ratios of accounts receivable are not strongly associated with the lowest operating cost ratios.

On the basis of this finding, a concentrated examination was conducted on both the ratio of the operating cost variable and the ratio of the accounts receivable variable in search of more definitive trends. A distinctive pattern was found by cross-tabulating the ratios of the operating cost and accounts receivable variables while controlling for the routine daily decision maker variable. The results of the examination are reported in the next subsection.

E. COMBINING NUMBERS AND PEOPLE

Table 27 shows a cross-tabulation of the ratio of the operating cost compared to the ratio of the accounts receivable while the office manager is the routine daily decision maker. A very close correlation is

TABLE 27

OFFICE MANAGER

Ratio of operating cost by ratio accounts receivable while controlling for routine decision maker--Office Manager.

Operating Costs	Accounts Receivable
0.28	4.00
0.32	3.00
0.34	3.70
0.38	2.75
0.54	2.17

presented. When the accounts receivable are lowest, the operating costs are the highest. Except for the relatively close operating cost ratios of 32 and 34 percent, the table shows that each increase in the accounts receivable ratio produces a decrease in the operating cost ratio. This trend was not discernable in the general cross-tabulation between the ratios of the operating costs and accounts receivable when the routine daily decision maker was not considered. The table reveals that the cost of reducing the accounts receivable 1.8 months is a 26 percent increase in overall operating expenses.

TABLE 28

ALL OWNERS

Ratio of operating cost by ratio accounts receivable while controlling for routine decision maker--All Owners.

Operating Costs	Accounts Receivable
0.45	4.00
0.63	2.00
0.67	1.80
0.73	4.00

Table 28 is the same cross-tabulation except that "All Owners" are now the routine daily decision makers instead of the "Office Manager." Note first, the increase in overall operating cost percentages. Nearly all are higher than the highest ratio from Table 27. Next, notice that the accounts receivables are in the same general range as the previous table. This clearly says that even though the accounts receivable are the same, operating costs are higher. Third, notice that there is a trend for the higher operating costs in Table 28 to be associated with the lower accounts receivable. This is the same trend that was noted in Table 27; lower accounts receivable ratios result in higher operating cost ratios. The data shows that changing the routine daily decision maker from "All Owners" to "Office Manager" can cause the ratio of the accounts receivable to stay at 4.00 while the operting costs drop from 45 percent to 28 percent. This data appears to be indicative of a healthy trend.

V. DISCUSSION AND CONCLUSIONS

A. PHYSICIAN MANAGEMENT EDUCATION

In Section II of this report, Strumpf was quoted as saying "Authors of studies of unsuccessful medical group practices have concluded that failure to observe basic principles of organization and management was the cause . . ." [Ref. 27: p. 7]. A telephone interview with Doctor Count D. Gibson [Ref. 30], Chairman of the Department of the School of Medicine at Stanford University, shed some light on why physicians failed to observe basic principles of management. Dr. Gibson said, "Students come to us blissfully ignorant of management. Four years later, they leave here as physicians, still blissfully ignorant of management." In a separate interview, one physician (Appendix B) posited that medical schools do not teach management because it would appear too mercenary. Dr. Gibson says that there just is not enough time in the schedule. There are too many medical things that have a higher priority. Dr. Gibson conjectures that physicians do not really need a management education. "Physicians are successful because of the power of life and death, not because they are good managers." [Ref. 30] Finally, Dr. Gibson theorizes that one of the major factors in the decision of a physician to join a group practice is ". . . to absorb management techniques through apprenticeship" [Ref. 30].

This study pursued Dr. Gibson's theory on physicians' motivations for joining a group during personal interviews with physicians that had chosen to practice medicine with a small group practice (Appendix B). Each

physician was asked why he joined a group practice. The most often cited reasons were scheduled nights off, continuity of care during vacations, and the advantage of peer consultation. Financial reasons were cited once and access to an already established body of patients was mentioned twice. Only one of the six physicians interviewed said that management knowledge and support was a factor in his decision to join a group.

When asked what the biggest managaement problem was, there was no hesitation in their responses, as five out of six emphatically said managing employees; the other said paperwork. The physicians left little doubt that management was a major problem. When queried about physicians in general being poor managers, five of the six again firmly stated that physicians are poor managers. They offered excuses such as lack of training, insufficient time, and dedication to medicine for their managerial reputation. All of the physicians interviewed expressed a desire to know more about management, however, not one expressed a desire to take a management course or indicated a willingness to spend time studying the subject. Medical interests and relationships with patients were much more important than the nebulous concept of management. It appears that although management apprenticeship may not be a major factor in the decision of a physician to join a group, Dr. Gibson is correct in that physicians, in general, do obtain their management expertise by on-the-job experience.

B. BASIC CHARACTERISTICS

A review of the characteristics of the small group physician practices in this study revealed general similarities to those suggested in the literature. Etzioni [Ref. 13] related that expert-oriented persons that

are managers tend to focus on their specialty and neglect their management responsibilities. The empirical evidence, documented by the personal interviews, disclosed that physicians are primarily concerned with practicing medicine. Their involvement with management is only to the level of taking care of immediate problems.

Beck stated that he is "constantly amazed at the number of group practices having no idea of their collection ratios, their accounts receivable outstanding, and other basic management information. Common sense seems to require regular bookkeeping and reporting so that such items remain within the partners' knowledge." [Ref. 23: p. 114] The organizations in this study exemplify Beck's experiences. Most physicians did not know what their accounts receivable or ratio of operating costs were. Five of the 19 questionnaires that were included in the study were returned with the quantitative data section left blank. Some of the questionnaires contained handwritten comments such as "I'm sorry--I can't handle this," and "We are not yet computerized but these are interesting and important questions. I would like to know the answers myself." One can only speculate as to how many questionnaires were not returned at all because the physician did not know the data requested and did not want, for whatever personal reasons, to ask his bookkeeper for it. It seems that the two organizations cited above could have obtained the data from their bookkeeper. Perhaps the physicians are not aware that the bookkeeper has the data. Perhaps the bookkeeper wants to keep all of that management evaluating data away from the physician. Perhaps the bookkeeper does not have the data, either. Whatever the case or

cases, the stimulus of Beck's amazement appears to be endemic to the physician organizations in this study.

A related concern was cited by Cotton who said: [Ref. 25: p. 378]

> The other principal cause for the economic failure of groups is lack of sound fiscal control. Not a year goes by without my being asked to visit half a dozen groups with overhead trouble. I go and find they're netting less than half their gross. The gross itself is nearly always good. The trouble is they hire too much help, install fancy medical equipment they hardly ever use, put phones in every room, and go hog-wild on gadgets.

The organizations in this study are classical illustrations of the situations Cotton described. Seven out of the 14 practices that provided quantitative data net less than half their gross. There was no connection between the number of employees and the number of office visits per month. Nor was there any connection between the percentage of the gross earnings spent of labor and the number of employees. Cotton would feel right at home in these practices.

Newman allows a change of focus. The characteristic he describes is one of the motivators that cause physicians to joing a small group rather than a large one. Newman relates: [Ref. 28: p. 24]

> Although we are located 100 yards from a new purpose-built health centre that runs a system of appointments, only we are embarrassingly deluged by a constant flow of patients wishing to change--not to us, we believe, but to our system, where the doctor can be seen if necessary on impulse, on the same day.
>
> If we had a large number of patients necessitating an increase in the number of partners beyond three, I do not think that we could maintain the old tradition of personalised family medicine and fulfill the concept of the personal doctor. I have been fortunate for a quarter of a century in living and working in a happy practice, and I cannot see any way in which enlarging it beyond the number of three would enable me to continue this happy professional life.
>
> If you can get it right, three is the magic number.

The warmth, concern, and care for the patient has been generally ignored in this study. Still, the physician interviews revealed that the organizations sampled do have the traits that Newman described. The ultimate concern of each physician was the welfare of his patients. While discussing employee performance, the physicians made it clear that rudeness to a patient was strictly forbidden. They seemed to condone excessive waiting, but only because of medical emergencies, not because of poor scheduling. The physicians, in general, were very concerned about having a happy practice to live and work in.

The final characteristic that is supported by the literature is avoidance of consultants. Tibbits provides the following reasons for such avoidance: [Ref. 4: p. 7]

1. The small business person views the use of consultants as an admission of failure,
2. The differences in education and background between the two parties preclude the development of a good working relationship,
3. The small business person does not know how to select an appropriate consultant, or
4. The potential benefits do not justify the cost.

None of the organizations in this study have employed a management consultant. One had considered it, but felt the cost was prohibitive. Another related that all of the good consultants were on the road, teaching management short courses. Some physicians may feel that because they are experts in medicine, they have to be experts in everything that deals with their practice. Therefore, calling in a management consultant might appear to the employees as an admission of failure. The ambivalent attitude taken by physicians on the subject of management is most likely a facade. The other reasons cited by Tibbits for not using consultants

are probably symbiotic. There are very stark differences in the education and backgrounds of physicians and management consultants. Considering the paucity of the average physician's managerial education, he could not reasonably be expected to know how to select an appropriate consultant. Not knowing what management is, or what it can do for an organization precludes the ability to conduct a rational cost/benefit analysis on obtaining a management consultant.

The traits discussed above represent core features of the physician group practices that were evaluated. In summary, the five characteristics of small group physician practices that have been discussed are:

1. Experts manage the organizations.
2. Owners are generally not aware of the financial statistics within their practice.
3. Overhead costs are excessive.
4. A desire to provide warm, personal service.
5. A tendency to avoid management consultants.

These five characteristics seem to permeate most of the physician practices in this study. Small group physician practices that have the characteristics described above need some type of management guidance to help them control their costs and develop a pleasant working atmosphere.

C. BASIC GUIDANCE

A set of basic guidelines has evolved from all of the data collected in this study. The basic guidelines are particularly applicable to small group physician practices that demonstrate the five characteristics described in the previous section and whose owners do not desire to obtain a management education. However, larger physician goups and

management consultants may also find them of interest. The guidelines are:

1. Reach management decisions, make personnel decisions, and resolve strong disagreement by consensus.
2. Schedule more than 300 office visits per month.
3. Have a full time staff (including physicians) of seven to nine people.
4. Establish a non-consulting spending limit no lower than $300.
5. Encourage an atmosphere whereby suggestions for improvements are stimulated.
6. Maintain the accounts receivable ratio between 2.75 and 4.00 of the average gross monthly earnings.
7. Use the ratio of the operating costs as the barometer of efficiency. It should stay below 40 percent of the gross monthly earnings.
8. Employ an office manager.
9. Most importantly of all, delegate routine daily decision making authority to the office manager.

The guidelines presented above are the major conclusions of this study. They represent the critical elements found within the physician group practices that made the difference of whether 28 percent or 73 percent of the gross monthly earnings were chewed up in operating costs. Although the 28 percent and 73 percent organizations were the extremes, far too many practices were way above the reasonable 30 to 40 percent range.

The guidelines should be evaluated for applicability to each specific organization. As a package, they are a solid base upon which to gauge whether an organization is efficient. Organizations that demonstrate variances from the guidelines should be evaluated to ascertain whether the variance is justified in the specific situation. The guidelines

represent dollar savings through better management without sacrificing the quality of patient care. It is the author's conviction that future research will strengthen the guidelines developed in this study.

APPENDIX A

MAIL SURVEY DOCUMENTS

Richard A. Blanchette
SMC #1484
Naval Postgraduate School
Monterey, CA 93940
Date

Physician Name
Physician Address
Physician City & Zip

Dear Doctor Whichever,

I am a Navy Medical Service Corps officer working on a Masters Thesis in Management Science at the Naval Posgraduate School in Monterey. As part of the thesis project I am conducting a survey of physician office practices. I am interested in how management decisions between quasi-equal owners are reached, and what guidelines are used to make staffing decisions. I have enclosed a survey form that asks for some data about your organization and I solicit your cooperation in providing the information requested.

This is not a Navy or U.S. Government survey, it is a personal effort. You were selected as a recipient of the questionnaire from the local telephone directory. The data will be grouped, compared, crunched in the the computer and evaluated for patterns and trends. All the information collected will be kept completely confidential, and no organization will be identifiable in the thesis report.

Your help in contributing to the knowledge of office practices is deeply appreciated. An envelope is enclosed for return of the completed questionnaire. If I can clarify any issue or assist you in any way, please telephone me at 646-3020 or 646-2536.

Appreciatively yours,

Richard A. Blanchette

THE DATA REQUESTED PERTAINS ONLY TO THE MEDICAL PRACTICE AT THE LOCATION TO WHICH THIS QUESTIONNAIRE IS ADDRESSED

Physician Name
Physician Address
Physician City & Zip

PLEASE COMPLETE THIS QUESTIONNAIRE AS FULLY AND COMPLETELY AS POSSIBLE

Medical specialty practiced _____

Number of physicians in the practice _____

How long has the current relationship existed (____ yrs ____ months)

FOR THE NEXT SERIES OF QUESTIONS, MENTALLY NAME EACH PHYSICIAN AS A, B, C, OR D.

Who makes the routine daily administrative decisions?

____ owner A
____ owner B
____ owner C
____ owner D
____ office manager
____ majority
____ whoever is around
____ unknown
____ all owners by agreement
____ no one

Who signs the checks for the group practice?

____ owner A
____ owner B
____ owner C
____ owner D
____ office manager
____ whoever is around

Who makes decisions on personnel matters such as hiring, discipline, dismissal, and pay raises?

____ owner A
____ owner B
____ owner C
____ owner D
____ office manager
____ whoever is around
____ all owners by agreement
____ unknown
____ no one

Is there any one person that tends to initiate discussion on changing things?

____ owner A
____ owner B
____ owner C
____ owner D
____ officer manager
____ other employee
____ no one person

How are management decisions reached within your organization?

____ unknown
____ consensus
____ bargaining
____ procrastinate
____ ignore
____ continual conflict
____ dominant person prevails

How would a situation of strong disagreement between the partners be resolved?

____ unknown
____ consensus
____ bargain
____ procrastinate
____ ignore
____ continual conflict
____ dominant person prevails

What is the average length of time a patient spends in the waiting room?

_____(minutes)

What dollar value would one owner feel comfortable spending on a one-time basis without consulting other owners? _____

Do you believe that the ratio of accounts receivable over gross monthly earnings is the best way to measure administrative efficiency in your office? ____ Yes ____No

What other methods would you suggest?

QUANTITATIVE DATA

Total number of office visits per month (average) _____

Total number of administrative and professional staff (include physicians)

Full-time _____

Part-time _____

The following four questions ask for ratios only. Do not provide actual dollars unless it is more convenient for you.

Ratio of accounts receivable divided by gross monthly earnings. _____

Monthly employee labor cost (excluding owners) divided by gross monthly earnings. _____

Total monthly operating cost (including employee labor) divided by gross monthly earnings. _____

Total monthly operating cost (including employee labor) divided by number of office visits per month. _____

THIS COMPLETES THE SURVEY QUESTIONNAIRE

THANK YOU FOR YOUR COOPERATION

Would you like a copy of my completed thesis report? ___Yes ___ No

Second-Mailing Label

For the second mailing, this self-adhesive label was placed obliquely on the cover letter.

PLEASE EXCUSE MY ANXIOUSNESS
IF YOU RECENTLY RESPONDED TO
MY SURVEY LETTER OF 7 SEP.
IF NOT, MAY I EMPLORE YOU TO
RESPOND TO THIS LETTER.
I DESPERATELY NEED THE DATA.

APPENDIX B

PHYSICIAN INTERVIEWS

As presented earlier, there were two reasons to conduct the personal interviews and observations. First was the desire to discover what areas of importance to the physicians were not addressed by the questionnaire. Secondly was the desire to explore and document the managerial philosophies of physicians in small group office practice. Appointments were made with the respondent physician specifically. A definite time slot of 15 to 20 minutes was established as the duration of the interview. The interviewer arrived at each physician's office 15 minutes early to allow time for possible general observation of the office operations. The interview queries were open-ended to allow as much freedom as the physician desired in his response.

A. PHYSICIAN INTERVIEW AND OBSERVATION #1

The waiting room was spacious and airy. Two walls were composed of sliding glass doors that allowed a promising view of plants and shrubs thriving and growing within ten feet of the comfortable-looking, wood-framed waiting room furniture. The administrative office spaces were just behind the waiting room. A 20-foot long counter separated the two rooms. The reception area of the counter was open to ceiling height and about eight feet wide. The rest of the counter area was enclosed by glass. The design evoked an airy, light, open, and growing atmosphere.

The receptionist was courteous as she asked if she could help me. As I introduced myself, I was pleased that she knew about me and did not ask if I were a patient. I accepted her knowledge of me as an indicator of good

internal communications within the office. The receptionist stated that the doctor was currently seeing the last scheduled patient and that he would see me immediately thereafter. I sat in the waiting room and observed the office staff and surroundings. There appeard to be a good deal of joviality and interaction among the staff. Although low in volume, the enthusiastic nature of the interpersonal communications indicated an absence of intimidation and formalized superior-subordinate relationships among those four employees that I observed during my brief wait. I was awakened from my observations rather abruptly when my consciousness finally registered that the receptionist had asked me to step into the doctor's office. I had only waited five minutes and was being seen ten minutes prior to the scheduled appointment time.

As I shook hands with the physician and sat down, I thanked him for responding to my questionnaire. His manner was friendly as he responded to the open-ended queries. The following is a synopsis of the interview.

Query: Why did you join a group practice?

Response: To gain entry to the community without spending years building up a practice. Joining a group also assures acceptance of the physician by the local medical community. There is the added benefit that one can obtain better facilities and equipment in a group practice because of the shared capital expenditures, but that was not a major consideration.

Query: Did you confer with others before filling out the questionnaire?

Response: No.

Query: A general criticism is that physicians are poor managers. How do you feel about that?

Response: That is generally true out of necessity. If the physician wants to be a good specialist, he cannot afford the time and effort required to be a good manager. I could not have the practice that I have without an office manager. No doubt about that. In this practice, the physicians make the final policy decisions, but the office manager develops the pros and cons of the alternative choices.

Query: How do you feel about health care administrators in hospital settings? Do they hinder you from doing what you want?

Response: Administrators are essential in allowing me to do what I want to do. They remove the administrative burden from the physician which allows him more time to play doctor. The hospital industry has marched over, around, and through physicians. The trend in the last five years has been such that physicians no longer have any management input into the operation of hospitals. The change is for the better because physicians are not cut out to be administrators of hospitals.

Query: How do you measure administrative efficiency?

Response: You have to look at the level of personnel turnover. Quality of people is important; peer group support is infectious among the office staff and tends to improve the quality of the staff. Another measure of efficiency is the level of complaints that I receive from the patients. Patients do not hesitate to let me know if someone was rude to them or if they are waiting too long for their insurance papers to be processed.

Query: What is your biggest management problem?

Response: Paperwork. Documenting the diagnosis and treatment of patients and responding to requests for medical information from insurance companies, attorneys, and employers is extremely time-consuming. Unfortunately, the physician must perform those tasks; there is never enough time.

Query: What would the ideal partner be like?

Response: The most important thing is that I must be confident in the partner's competency level. I depend on my partners to provide care to my patients when I am absent and I must be confident that I will not have to correct their mistakes. Professional competency is the primary overriding requirement. I would prefer to tolerate a dogmatic individual that was competent than to suffer under an easy-going bungler. With competency assumed, I would then seek an individual that held interests in a different sub-specialty area than my interests. For instance, if I were an internal medicine physician with an interest in cardiology, I would team up with an internal medicine partner with an interest in nephrology rather than one with an interest in cardiology. Similar sub-specialty interests tend to cause disagreements about the most appropriate therapy for a given case. Different sub-specialty interests, however, round out the practice and provides additional specialty services within the organization.

The physician was asked if there was anything else that he would like to add or if he had any questions about the study. He responded that he did not have any at the moment but would really like to see the finished

report if possible. He was assured that he would receive a copy and the meeting ended. As I departed, I noted again the quiet joviality of the office staff. The receptionist said good-bye and wished me a good day. I thanked her and departed.

B. PHYSICIAN INTERVIEW AND OBSERVATION #2

Observations of the office operations reflected the organizational culture. Although the waiting room was new, it held a sense of constraint and confinement. The reception desk was excessively wide, approximately 15 feet, but it was flanked by walls on either side that went to the ceiling. The design of the walls were vertical slats of wood, which added to the domineering appearance and contributed to the feeling of being enclosed.

The waiting room furniture was a variety of solid and plaid colors that did not seem to fit the rest of the decor. In the middle of the room, there was a stand with three baskets of fern plants which appeared artificial or stagnant. The design and furnishings reflected very little thought of the psychological state of the intended users.

When I approached the reception desk, I gave my name and stated that I had an appointment with the physician. The receptionist looked at me quizzically and asked if I was a patient (an indication of poor internal communication). I responded in the negative and she then said that she would tell the doctor that I was waiting. I invited myself to have a seat and continued the observations.

It was only seconds before I overheard a receptionist say to a patient, "I don't know what to suggest." The patient was indecisive about whether she should wait to see her doctor or not. She asked the

receptionist for a recommendation. The receptionist responded that the patient "should wait or make another appointment." The receptionist could not provide any indication of the expected time the patient would be seen.

The staff appeared very busy but confused; there was a lot of whispering among the two receptionists and a lot of paper shuffling. The patient medical records are stored directly behind the reception counter. Patients witness the confusion of the staff when records are not immediately locatable. Adjacent to the walls flanking the reception desk are two doors. One of those doors suddenly opened. The sound of a name came though the open space. A person in the waiting room got up and went through the doorway. The door closed. Shortly thereafter, the scene was repeated by the door on the other side of the room.

Attention is shifted by confused voices in the reception area trying to figure out who is on hold on the various telephone lines. There is a three-way discussion about which numbers wanted to talk to whom about what. A few minutes later, a staff worker commented that one of the telephone calls was switched to the wrong person but it was alright because she handled it. The receptionists do not identify themselves when they answer the telephone. It was now five minutes past the scheduled appointment time. No one offered an explanation for the delay, and there was no indication of when the doctor would be available.

A new round of confused conversation ensued when a nurse asked the receptionist when a certain patient was scheduled to return. In a defensive tone, the receptionist said, "She [the paitent] went with you down the hall and we never saw her again." After a few more exchanges,

the receptionist was explaining something to the nurse when the nurse simply walked away and left the receptionist talking to herself. It was only about 30 seconds later when another office worker entered the reception area and said to the receptionist, "You're supposed to be at home." The receptionist responded with, "I know it. I haven't been able to get out." The way she used the words "get out" gave the impression that she was confined.

Just then one of the doors swung open and my name came through the opening. I obediently got up and walked through the opening. I was greeted on the other side by a nurse who apologized for keeping me waiting (only eight minutes late) and said that there was some confusion because she had me on the schedule for the next day. I quickly checked my appointment book and verified that I was in the right place at the right time.

My introduction to the physician was somewhat awkward because he was in an examining room collecting instruments. We shook hands and went to his office where he apologized for the clutter as he struggled to clear a chair for me to sit on. The physician stated that he was glad that he spotted me in the waiting room because he was getting ready to leave and did not know that I was there. A synopsis of the subsequent interview follows.

Query: Why did you join a group practice?

Response: The primary reason was security. Joining an already established practice meant that I would immediately have as many patients as I could handle. There is also the benefit of peer consultation. I never considered solo practice. There are too many

unknowns in how a practice operates. I wanted the support of someone that had the experience of running a practice. Group practice also assures the physician that his best interests are going to be considered in his absence. A solo practice physician must refer his patients to a competitor during illness or vacation. The competitor may well disagree with the prescribed course of therapy and make damaging comments to the patient. Group practice removes the probability that patient complications might be handled less than tactfully in your absence.

Query: Did you confer with others before filling out my questionnaire?

Response: No, I did not. I guessed at a few of the numbers but I felt they were close.

Query: A general criticism is that physicians are poor managers. How do you feel about that?

Response: That is definitely true. Physicians have no preparation for management; no administrative exposure. I went from medical school to internship where the patients just somehow showed up. I received a little management responsibility in the Army but no training. Physicians that can manage are few and they are well known. The normal physician is afraid to handle administrative matters in his office.

Query: How do you feel about health care administrators in hospital settings? Do they hinder you from doing what you want?

Response: They have no influence on me at all. Most physicians have a paranoia about health care administrators. The physicians seem

to think that the administrators have a diabolical plan to take over the world. The physicians fear that hospitals may become competitors of their office practices in the future.

Query: What is your biggest management problem?

Response: Managing employees. We have had a lot of bad luck with office help. They are not well paid but we can't really afford to pay big salaries. We have an office manager, but she is just a receptionist that was promoted to office manager status because she has been with us for so long. We don't pay her very well, either. Principally, our problems are with the two receptionists; hiring and discipline is difficult. In the last four months, we have had two resignations and one firing. We had good luck recently. We now have a good team. The employees are doing a reasonably good job and we are currently satisfied. My partner has more say on these type of decisions. He has been in practice ten years longer than me and has more experience. I defer to his judgment.

Query: What would the ideal partner be like?

Response: Personal compatibility is the most important thing. Unless I could get along with him the partnership would not last. Secondly, I would look for someone that would fill out and support my weak areas; someone that was strong in my knowledge deficiencies.

When asked if he had anything else that he would like to add or if he had any questions about the study, the physician replied that he felt a management course in medical school would be extremely helpful, but he

doubted if it would really happen. I thanked him for his help with the study and departed through a confusing maze of corridors that bypassed the reception desk.

C. PHYSICIAN INTERVIEW AND OBSERVATION #3

The waiting room was small and simply furnished. Chairs were placed along three of the walls, and the standard four foot wide by three foot high hole in the wall reception counter dominated the fourth wall. I gave my name at the counter and stated that I had an appointment with the physician. The receptionist immediately asked if I had been seen there previously. I explained that I was not a patient. She checked the appointment book, noted a code that verified my non-patient status, smiled, and said, "Fine, I'll tell the doctor you are here. Please have a seat."

The wating room did not feel enclosed. The furnishings all had lean lines and seemed to fit well. Nothing looked as if it should not be there. The ceiling helped provide an airy feeling. It sloped steeply upward to about 15 feet high within a ten foot distance. One of the office workers entered the waiting room and chatted with a mother who was waiting with her infant child. Their conversation was about how big the baby had grown since the previous visit. Sounds of cheerful conversation spilled out of the reception area. Modest laughter and teasing between the officer workers helped provide a relaxed atmosphere.

As a patient was leaving (through the reception and waiting room area), the receptionist said good-bye and the patient responded with a good-bye and a smile. A man and woman entered. The woman had obviously injured her right ankle. The man gave the receptionist his name and said that he had

telphoned ten minutes ago. The receptionist said, "Oh! Yes. Go right down to x-ray; they are waiting for you." A nurse that was nearby said to the couple, "Wait a minute. I'll get a wheelchair." Although in obvious pain, the woman was just as obviously grateful for the consideration the staff was showing.

At one minute past the scheduled appointment time, the receptionist asked a nurse, that she had been chatting with, if the other receptionist had ever informed the doctor that I was waiting. The nurse said that the doctor still had three patients to see. The nurse then looked over at me, and told me that it was going to be a while. I told her that it was o.k.; I had plenty of time. She smiled and left to tend a patient. A departing patient stopped at the desk to schedule a follow-up appointment. The dialogue was very considerate:

Receptionist: Is morning of afternoon best for you?

Patient: It doesn't matter.

Receptionist: Is ten o'clock too early?

Patient: No. That will be fine.

Receptionist: O.k., ten o'clock on etc. We'll see you then. Take care.

Shortly thereafter, another patient stopped on the way out to schedule a return visit. The friendly consideration never faltered; not even around the guessing by the mother about what time her children get out of school.

The physician entered the waiting room twenty minutes past our scheduled appointment time. He was friendly and seemed very interested in being of assistance. A synopsis of the interview follows.

Query: Why did you join a group?

Response: Primarily for financial reasons. I didn't have the money to go it alone and I received an offer with no investment required. Another strong factor was sharing night calls. I needed to have some time to myself and my family. A third benefit of group practice is the access to peer consultation on an informal basis. That really strengthens a practice.

Query: Did you confer with others before filling out the questionnaire?

Response: No. There was nothing in the questionnaire that I felt would be harmful or controversial to the group practice.

Query: A general criticism is that physicians are poor managers. How do you feel about that?

Response: Generally true. A fair statement.

Query: How do you feel about health care administrators in hospital settings? Do they hinder you from doing what you want?

Response: The relationship has changed over the last five years. There used to be a good partnership. Now the relationship is such that the physician is just another one of the many providers of services to the hospital. Nursing now has the dominant role. The day to day operations of the local hospital has been unofficially assumed by the Chief of Nursing. The Chief Administrator is too busy; as an assistant administrator, the Chief of Nursing is making administrative decisions that are all biased toward the nursing staff. The hospital needs an associate administrator to neutralize the partiality toward nursing concerns.

Query: What do you use to measure administrative efficiency of the group practice?

Response: I am primarily concerned with the efficient utilization of time. I don't want ten patients stacked up waiting to see me and I don't want to be sitting around waiting because a 15 minute follow-up paitient was scheduled for a 30 minute appointment. The appointments cannot be over- or under-booked; returning patients must be scheduled to see the correct physician and all supporting documents, such as the patient's record, special test results, and so forth, must be assembled and ready for physician review. I also measure efficiency by how well the staff judges the patient's needs. Whether a patient needs to be seen in ten minutes or one week is an important decision that is generally made by the receptionist over the telephone with information from a patient that may not be totally rational. It is an important decision because it could result in unnecessary damage to the patient on the one hand, or an unnecessary waste of a physician's time and an office visit on the other. How well the staff screens those telephone calls and makes the correct decision is a strong measure of an efficient office.

Query: What is your biggest management problem?

Response: We recently changed our computer support company. We are having a miserable time with the transition. We went from approximately four errors per 1,500 records to about 700 errors per 1,500 records; so that is the big problem of

the moment. Other than that, tardiness and bickering among the office staff has been a problem. About six months ago, we hired a male bookkeeper/office manager and a lot of the problems ceased. However, the problems are starting up again and I guess we'll have to do something about it sooner or later.

Query: What would the ideal partner be like?

Response: In order of priority--medically well-informed, good ethics, moral, not lazy, conscientious, good judgment, not overly aggressive on decisions to provide excess care solely for the profit motive.

Query: Is there anything else you would like to contribute to the study?

Response: Only a general complaint that medical schools do not prepare physicians for management of our practices. About 90 percent of all physicians have a practice to manage or work for an institution that demands that physicians manage.

I thanked him for his assistance with the study. As I departed, he expressed an eagerness to see the final report. He was assured that he would receive a copy.

D. PHYSICIAN INTERVIEW AND OBSERVATION #4

As I walked up to the recessed bay window-shaped reception counter, I noticed that the waiting room was rather large. The room had a quadrilateral shape that provided a sense of depth and roominess that would not have been attained with 90 degree wall angles. The main entrance door

was glass with large six foot wide windows on either side. Several different kinds of small plants were scatterd throughout the room. The receptionist knew who I was. Before I could introduce myself, she said that she would tell the doctor that I was waiting. I had, according to the planned routine, arrived 15 minutes early. As the receptionist invited me to have a seat, I looked forward to observing the staff and appraising the 30 gallon fish aquarium that sat beside the reception counter. I had barely sat down (about ten seconds) when the receptionist called my name and escorted me to the physician's office.

As the physician invited me to sit down, I thanked him for responding to my questionnaire and explained the general scope of the study. As synopsis of the interview follows.

Query: Why did you join a group?

Response: Primarily because of the shared responsibility. I don't have to deal with every aspect of the management of the practice. Each physician is responsible for a section. I make all of the routine financial decisions and deal with the banks. One of the other partners handles all of the personnel problems. He does the interviewing, hiring, discipline, and so forth. The thrird partner has the physical plant. He takes care of everything from burnt-out light bulbs and cleanliness to air conditioning maintenance.

A second reason why I joined a group is the shared responsibility in medicine. I am only on call every third night. I know that when I am not available, my paitients are being taken care of by people I trust. I get feedback on what they did for my

patients and the group practice therefore provides a continuity of care for the patients. There are, of course, drawbacks to group practice. I can't fire anyone I please any time I please. I can't make routine decisions outside of the financial arena by fiat. I must respect the other physicians' areas of responsibility.

Query: Did you confer with others before filling out my questionnaire?

Response: No.

Query: A general criticism is that physicians are poor managers. What do you think?

Response: Physicians have been hiding behind that for years. The concept is fostered by Practice Management people that would like to charge $50,000 per year to relieve the physician of the management burden. A lot of physicians are good managers; some are not.

Query: How do you feel about health care administrators in hospital settings? Do they hinder you from doing what you want?

Response: That depends on the hospital. In a small proprietary hospital, there is no problem because the physicians still have the upper hand. If the administrator does not bend, he is replaced. In a county hospital, the administrator is a real hinderance to the development of quality care. His focus is on cost reduction, not good care. My ideals differ from the administrator's. At the local county hospital, the administrator refuses to expand the alternative birth center, yet he is putting in concrete gutters all around the hospital roadways.

Query: How do you measure administrative efficiency?

Response: Accounts receivable divided by the gross monthly earnings only measures the efficiency of billing. The collection ratio is more useful: monthly collections divided by monthly billings. Each employee has a job description by which their performance is evaluated to ensure that their tasks are being done properly and timely. It is important that invoices are sent to insurance companies two days after a patient's surgery rather than ten days. They take a long time to respond to claims.

Query: What is your biggest management problem?

Response: Personnel. People are harder to deal with than money. It is difficult to find employees that can work together and get along. We have had a high turnover rate, but are now in pretty good shape. There is one employee that I would like to get rid of but my partners both feel that she is worth keeping.

Query: What would the ideal partner be like?

Response: He would have to be about the same age as I am, have received identical training and have a similar general philosophy of medicine. He would have to be someone that I would feel comfortable having my patients see. We are currently considering expanding the practice to include a fourth partner, and one of the possible candidates is a female. I don't see that the sex of the physician partner is a factor. I must feel reasonably comfortable with the ideal partner. The partner should be a friend within social settings.

Query: Is there anything else that you feel may be of assistance to physicians in managing their group practices?

Response: It is important in a group practice to maximize the benefits of being in a group while minimizing the detriments. The physicians need as much professional independence as possible, yet be able to consult spontaneously when desired. Work spaces should be shared to the minimum amount necessary. Each physician should arrange his own work space to fit his personal preferences. Sharing work spaces and examination rooms is a normal group practice hassle. Our monthly staff meetings are very helpful to us. Everybody is expected to attend and participate in the discussion of problems and potential solutions. In fact, we have having our monthly staff meeting in two minutes; so I'll have to go.

I thanked the physician for his time and walked with him to the waiting room where the rest of the staff was sitting around chatting and getting out their bag lunches in preparation for what appeared to be a very informal conference. As he said good-bye, I noted that everyone in the room looked relaxed, yet enthusiastic.

E. PHYSICIAN INTERVIEW AND OBSERVATION #5

Walking into the waiting room was like entering kiddieland. There could be no disguising that this was the waiting room of a pediatric specialty. Brightly colored built-in benches that were padded to prevent accidental injury decorated the left side of the room. An enormous open counter wound around the right side in an S-shape for about 35 feet. A

solarium allowed children to play outside while in the waiting room. An enormous effort had been made to reduce the fear and anxiety of the potential patient.

Even though I had arrived the normal 15 minutes early, when I introduced myself at the reception counter, I was immediately shown to a room behind the reception office. The room was a group office for the physicians. Four desks lined the walls. I was offered a seat at a small conference table along one wall. The physician entered the room within 15 seconds. He introduced himself and asked for a small briefing on what I was doing. His keen interest was noticeable, as I related the general concept of the study to him. The interview followed the same format as the previous encounters. A synopsis follows.

Query: Why did you join a group?

Response: Because a group has many advantages. We share night calls, it is easier to take time off, and we can schedule firm vacations. Peer consultations are also very important. They are difficult to achieve in large groups. The three of us get along very well. The peer support we provide each other is a big contribution to our success. Financial considerations were not a factor in my deciding to practice medicine with a small group.

Query: Did you confer with the others before filling out my questionnaire?

Response: No. I did it myself.

Query: A general criticism is that physicians are poor managers. What do you think?

Response: Absolutely true. I have been in practice for twelve years, and I have only felt comfortable about managing my practice in the last two years or so. I have found that it is very difficult to correct mistakes made earlier. Our practice could have been managed better; no doubt about that.

Query: How did you become comfortable with managing; did you attend any courses?

Response: No, I don't have the time to take any courses. I learned from my earlier experiences. Eventually, I felt comfortable in making management decisions.

Query: How do you feel about health care administrators in hospital settings? Do they hinder you from doing what you want?

Response: I have been fortunate in that I have a good relationship with both administrators of the hospitals I practice in. I have been able to do pretty much what I want. I have found that the hospital administration has generally had a reasonable reason for their position on various issues. I can understand and communicate with them. I realize that there are legal, financial, and government forces that the administrators cannot control. The administrators must accept part of the responsibility for their general poor repuation with physicians because they have not explained to the physicians what the forces are that cannot be controlled. Physicians are not aware of all the regulations controlling the operation of hospitals.

Query: How do you measure the administration efficiency of your office?

Response: I look at people efficiency. We use a lot of part time help. It is not difficult to find part time help and it is slightly cheaper because you do not have to pay benefits. We have a lot of staff because we need back-up people for absences. Pediatrics has peak loads; we have to staff for the cold and flu season. I wish we could get rid of employees in the summer time, but you can't do that. We have to carry them. We use part-timers whenever we can. I should hope that our full time people could do all the bookkeeping and laboratory work, but they don't. We have to hire additional part-timers to help out.

Query: What is your biggest management problem?

Response: People. Personalities and mixes. There is always bickering among the employees about who did what when or who is not going to do what or some other minor stuff. It is all caused from differences in personalities. Some people just don't like others. We have monthly meetings with the entire staff and communications are good at that time, but there is a communication problem between meetings. People just don't seem to get the word. Right now, things are fairly good. The incentives are good.

Query: What would the ideal partner be like?

Response: First and foremost, he must have a reputation as a good Doc. His demonstrated abilities are more important than where he

attended medical school. Second, I must be able to get along with him, personality-wise. This is really important. Third, he must have the ability to compromise. We all make errors; partners must be able to admit their errors and grow stronger from the experience.

Query: Is there anything else that you feel is important in managing a group practice that you would like to contribute?

Response: We are not on a computer system, and I don't think that the software available today is yet good enough, but in the near future, using a computer in a group practice could save a lot of personnel problems. Also, the number of physicians is very important. There should be no more than four physicians in a group. With five physicians, it would be three times as difficult to manage this office. Communication is really important. Three physicians is nice, four is complex but tolerable, with five physicians, group communication is virtually impossible. Patients pick up when an office is not happy.

I thanked the physician for his time and departed through the waiting room where the office staff was eating bag lunches.

F. PHYSICIAN INTERVIEW AND OBSERVATION--EXTRA

A divergence from the criteria of interviewing only physicians in small group practice was permitted for this interview in order to obtain the perspective of a physician who had left a group practice three years earlier to start his own solo practice. His perspective was desirable

because of his reputation for rationalizing the management of a medical practice.

The waiting room was very small. There were two chairs against each side wall and one chair beside the three-foot square hole-in-the-wall reception counter. The main entrance door was all glass with an equal sized glass wall beside it. There were five different kinds of plants/ trees of varying sizes strategically placed throughout the area. The room had an airy and light feeling. A small aquarium, next to the wall of glass, provided a promise of continued life; the water bubbled soothingly.

I introduced myself at the reception counter and was promptly told that the doctor was with a patient and would be with me shortly. The receptionist then invited me to have a seat. I was alone in the waiting room. Three members of the office staff talked quietly amongst themselves. The subject of their conversation was not discernable, however, an occasional chuckle or laugh indicated that the atmosphere was very congenial and light. The design of the reception area provided a strong separation between the reception office and the waiting room. The office staff is effectively shielded from the inquisitiveness of waiting patients.

Approximately two minutes prior to the scheduled appointment time, the physician entered the waiting room and introduced himself. We went to his office as the departing patient was scheduling a return visit at the reception counter. As we entered the physician's office and sat down, I thanked him for seeing me and provided a brief description of the study. A synopsis of the interview follows.

Query: Why did you terminate your group relationship?

Response: We did not get along. I just do not get along with small groups. Actually, there are no advantages to small groups. The volume of demand is not sufficient to make the addition of adjunct services profitable. With large groups, the organization is big enough to hire a manager; small groups are too small for that.

In the group that I was with three years ago, I wound up doing all of the management. A management rotation system was initially established whereby each physician would take turns managing the organization. I did not like the way the other physicians conducted their management duties. I wound up doing all of the management and making all of the business decisions. The other owners did not see the need to hire a manager, and they refused to compensate me for my management efforts. The relationship could not continue. In my solo practice, I know that if a mistake is made, it is mine. I have control over all decision making.

Query: A general criticism is that physicians are poor managers. What do you think?

Response: Generally it is true. Physicians are constantly bombarded by demands. There are a tremendous amount of day to day hassles that deal with medicine. No way does the physician have the time to manage.

Query: How do you feel about health care administrators in hospital settings? Do they hinder you from doing what you want?

Response: I think that depends on the hospital and the administrator. When I was in residency, the county hospital administrators were always a pain in the neck because the objective of the county was to cut costs while the objective of the physicians was to provide quality medical care. Presently, there is no problem. I anticipate that there will be a problem in the future because the administrators are buying up most of the medical resources in this area; for instance, they own this office building. They are developing a monopoly.

Query: Who is "they?"

Response: The so-called non-profit hospital.

Query: How do you measure the administrative efficiency of your office?

Response: Accounts receivables are really helpful. I look for trends, up or down, of the amount collected versus the amount earned. I am here all of the time so I keep a pretty good eye on what is going on.

Query: What is your biggest management problem?

Response: Personnel; ensuring their presence, ensuring that the work is done, sorting truth from fiction when they tell me that the workload is too heavy. I have performed every job in an office setting. I know what to do and how long it takes to do it. I still tend to be too nice. I am too easy. I don't really have the time to check everything.

Query: If you decided to start up a new group, what would the ideal partner be like?

Response: Reliable and well-trained. He must have the same style of practice that I have. I would prefer to have some previous professional experience with the potential partner. Unless we were consistent in our therapy convictions, too much confusion would develop among the supporting staff and that would lead to friction in the office.

Query: Is there any one thing or area that you feel is important in managing an office practice?

Response: I was instrumental in arranging a Practice Management course while in residency. That course helped me tremendously. I would not have been able to set up my own practice without it. Every physician starting up a practice that I know, with the exception of one person, has had problems with groups. Medicine is a profession where the student has no concept at all about what being a doctor is like until he is in it. Medical schools frown upon adding management courses to their curriculum because it is so mercenary. I believe that Practice Management is a valuable part of training.

After I had been exposed to the rigors of office practice for some time, I felt a need to go out and tell people how to manage. I gave one lecture at a county hospital. There simply was no interest in the topic. Management was too nebulous a problem to deal with. I like teaching and I am good at it, but right now it is not my number one priority. Maybe later I will get into that. Really, the reason I don't give lectures is because I want to practice medicine.

I thanked the physician for his assistance with the study and informed him that the information he provided was very useful. He responded by saying that he was glad to help and that coverage of office staff and nurse assistance in a solo practice is a very difficult problem. As I departed, he commented rather forlornly that, "Group practice would be right if I had the right people." My impression is that he meant small group.

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